UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

JACK REESE, JAMES CICHANOFSKY, ROGER MILLER, and GEORGE NOWLIN on behalf of themselves and a similarly situated class,
Plaintiffs,
v.

CNH INDUSTRIAL N.V. and CNH INDUSTRIAL AMERICA LLC,

Defendants.
_____/

Hon. Patrick J. Duggan

Case No. 04-70592

Class Action

EXHIBIT O

To

PLAINTIFFS' RESPONSE TO CNH'S MOTION FOR SUMMARY JUDGMENT

Addenda to Preliminary Expert Report of Suzanne M. Daniels

December 16, 2013

REESE, ET AL V. CNH AMERICA, LLC, ET AL.

ADDENDA TO PRELIMINARY EXPERT REPORT OF SUZANNE M. DANIELS

DECEMBER 16, 2013

I have read Mr. Scott J. Macey's expert report. In these addenda to my original report, I will respond to Section II.B.3. of his report, entitled *The Increased Cost Sharing Is Not Likely to Adversely Affect Plaintiffs Health Benefits.* As I explain ahead, Mr. Macey's conclusion the increased cost sharing is unlikely to adversely impact the Class is not supported by the research he cites. This cited research does, however, support the opinions I stated in my original report.

Mr. Macey cites a Robert Wood Johnson report by Katherine Swartz, Ph.D., *Cost-sharing: Effects on spending and outcomes* as support for his opinion that " increased cost sharing is not likely to adversely affect the Plaintiffs Health Benefits". When taken in its entirety, the Swartz report does not support his opinion and instead provides additional support of my opinion that increased cost sharing will likely adversely affect members of the class.

Mr. Macey characterization of the Swartz report as "... a synthesis of what we know (and do not know) about the effects of cost-sharing on spending and outcomes" is incomplete and thus is somewhat misleading. The focus of Swartz's work is not to summarize the research on the impact of increased cost sharing in order to better understand the affect on individual participant's health status, utilization of services, etc. Swartz's focus is on the impact of plan participant cost sharing requirements on health care costs and outcomes on a population (i.e., macro economic) basis given recent health care legislation. Swartz states: "A synthesis of what we know (and do not know) about the effects of consumer cost-sharing can provide valuable information for policy-makers as the country implements the new health care reform law (PPACA). The law calls for different levels of coverage (bronze, silver, gold and platinum)... "[1]

Given Swartz's focus on the effects of cost-sharing within the context of PPACA, it is not surprising that many of the studies she references examine the effect of increased cost-sharing on individuals who are not eligible for Medicare; as Medicare is not structurally changed under PPACA. For example, Swartz discusses the finding of the RAND HIE Health Insurance Experiment (HIE) throughout the report. The author's emphasis on this study is not simply due to the fact the Rand HIE, conducted between 1974 and 1981, is the most recent large, longitudinal study that examined the impact variations in cost-sharing on health care costs and outcomes. Moreover, the population studied in the RAND HIE is similar to that which is affected by the PPACA. The Rand HIE study used a representative sample of families with adults under the age of 62, which is similar to the exclusion of Medicare-eligible participants from the PPACA market reforms.

Mr. Macey ignores Swartz's discussion of the limitations of the RAND HIE and

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[1] Swartz K, "Cost-sharing: Effects on spending and outcomes," *Research Synthesis Report, The Robert Wood Johnson Foundation*, no. 20, 2010, p. 1.

cautionary remarks about its finding. Mr. Macey simply states that that the Rand HIE "...found that "for the average person under the age of 62, there were no adverse health effects due to reductions in use of health care caused by cost-sharing." Swartz too quotes this same finding from the RAND HIE. However, she goes on to state, "...the HIE found that people with higher cost-sharing reduced their use of both appropriate and inappropriate health care services about equally."[2] Swartz highlights that the HIE found that people with cost-sharing reduced their use of preventive care such as immunizations for children and Pap tests for cervical cancer."[3]

Swartz cites the finding of other published research on the impact of cost-sharing on plan participants including some studies which exclusively examined changes in cost-sharing on Medicare-eligible participants, which do not support Mr. Macey's opinion. Below are some extracts from the Swartz report that clearly do not support Mr. Macey's opinion.

1. *For people with chronic conditions, cost- sharing reduced the use of essential drugs and was associated with increased use of other medical services, especially hospital care.* [4]

2. *Increased cost sharing for prescription drugs appears to cause increased expenditures on emergency department services and inpatient hospitalizations by elderly and welfare beneficiaries. While Chandra et. al. do not specifically estimate the cost-sharing effects on health outcomes, the findings that chronically ill people are more likely to be hospitalized and expenditures for them are significantly higher as a result suggests quite negative effects on the health of chronically ill older people.*[5]

3. *Increased cost-sharing disproportionately shifts financial risk to the very sick.*[6]

4. *Cost-sharing reduces the use of preventive services.*[7]

5. *Demand for mental health and substance abuse care is sensitive to cost-sharing, according to the limited research available.*[8]

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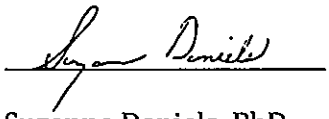
[2] Ibid., p. 16
[3] Ibid., p. 16
[4] Ibid., p. 20
[5] Ibid., p. 12
[6] Ibid., p. 22
[7] Ibid., p. 16
[8] Ibid., p. 17

In conclusion, Mr. Macey's opinion that increased cost-sharing is not likely to adversely affect the Class is not supported by the research he cites as the basis for his opinion.

Signature: 

Suzanne Daniels, PhD

December 16, 2013